BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JOSEFINA N. ALINCASTRE LLANOS** 1206 Norton Avenue Glendale, CA 91202 Registered Nurse License No. 353850 Respondent.	Case No. 2008-91 OAH No. L2008040180

DECISION

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **June 4, 2009**.

IT IS SO ORDERED this **4th** day of **May, 2009**.

Susanne J. Phillips, MSN, RN, FNP-BC
Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
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In the Matter of the Accusation Against: JOSEFINA N. ALINCASTRE LLANOS 1206 Norton Avenue Glendale, CA 91202 Registered Nurse License No. 353850 Respondent.	Case No. 2008-91 OAH No. L2008040180

DECISION

This matter was heard by Erlinda G. Shrenger, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on July 28 and 29[1], August 28, and November 25, 2008, in Los Angeles, California.

Anne Hunter, Deputy Attorney General, represented Complainant.

Phyllis Gallagher, Attorney at Law, represented Josefina N. Alincastre Llanos (Respondent), who was present.

Oral and documentary evidence was received.[2] The record was held open until December 17, 2008, for the parties to submit written closing briefs. Complainant's closing brief was timely submitted and marked as Exhibit 12. Respondent's closing brief was timely submitted and marked as Exhibit J. The record was closed, and the matter was submitted on December 17, 2008.

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[1] The second day of the hearing (July 29) was interrupted by an earthquake in Los Angeles. The hearing resumed on August 28, 2008.

[2] Pursuant to Complainant's subpoena, Good Samaritan Hospital produced Respondent's entire personnel file. At the hearing, pursuant to the ALJ's order, the parties selected the pages from the personnel file that they offered into evidence. Those selected pages, together with the subpoena documents, were collectively marked and admitted as Exhibit 7. The remainder of Respondent's personnel file was returned to Complainant's counsel.

FACTUAL FINDINGS

1. Complainant Ruth Ann Terry, M.P.H., R.N., brought the Accusation in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On October 31, 1982, the Board issued Registered Nurse License number 353850 to Respondent. The license was in full force and effect at all times relevant to the charges in the Accusation and will expire on January 31, 2010, unless renewed.

3. The Accusation seeks to impose discipline against Respondent's license for gross negligence, incompetence, and unprofessional conduct in performing her duties as a registered nurse at Good Samaritan Hospital on March 21, 2002. At issue is Respondent's interaction with a patient's family member who was visiting a patient at the hospital.

4. Patient J.S.[3], now deceased, was a 54-year-old male who was transferred from a nursing home and admitted to Good Samaritan Hospital on March 20, 2002, to be considered for placement of an implantable cardioverter defibrillator (ICD). In the operating room, he was emergently intubated and placed on a mechanical ventilator. The doctors determined patient J.S. was in a severely compromised state physiologically and canceled the ICD procedure. Patient J.S. was taken to the coronary care unit (CCU). He remained hospitalized at Good Samaritan Hospital until his death on April 4, 2002.

March 21, 2002, Incident

5. On March 21, 2002, Respondent was on duty as a registered nurse in the CCU. Her shift was from 7 a.m. to 7 p.m. She was assigned to provide nursing care for patient J.S.

6. Patient J.S. was assigned to Room 357 in the CCU, which is directly across from the nurse's station.

7. S.S. is patient J.S.'s sister. On March 21, 2002, at approximately 4:30 p.m., S.S. arrived at the CCU to visit her brother. S.S. and Respondent testified at the hearing and gave contrasting versions of the incident that occurred between them.

8. (A) According to S.S., the March 21 incident occurred as follows: While visiting patient J.S., S.S. noticed he was having difficulty breathing and that the tube in his mouth had filled with saliva. S.S. decided to call a nurse for suctioning. S.S. pressed the nurse call button several times, but no one responded. After waiting 10 minutes, S.S. stepped outside the room to look for a nurse. S.S. saw Respondent socializing with other nurses in the nurse's station. When Respondent saw S.S., Respondent jumped out of her chair and approached S.S. According to S.S., Respondent's "body expression lacked interest," her

[3] Patient J.S. and his family members are identified by their initials in order to protect their privacy.

"face showed anger," her "body showed a lack of concern," she appeared to be "upset," and she had a "negative attitude."

(B) S.S. asked Respondent to suction the saliva that had accumulated in the tube in her brother's mouth. S.S. felt Respondent performed the suctioning with a "very negative attitude" and in a "careless" and "upsetting" manner. When S.S. asked a question about the procedure, Respondent angrily said, "Are you telling me how to do my job?" Respondent then became "aggressive" and "violent" in suctioning the saliva from patient J.S. S.S. told Respondent not to be so upset. S.S. put her hand on Respondent's shoulder in an attempt to calm her down. S.S. claims Respondent screamed at her, "Don't touch me." From that point on, Respondent started arguing with S.S. inside patient J.S.'s room. S.S. walked out of the room in order to keep Respondent away from her brother. S.S. saw Respondent tell a co-worker that she [S.S.] had tried to pull her arm. S.S. spoke to Respondent's supervisor, Kelvin Matute, about the incident. After speaking with Mr. Matute, S.S. was too upset to return to her brother's room. She did not want him to see her crying. She waved good-bye to him from outside his room and left the CCU.

9. (A) According to Respondent, the March 21 incident occurred as follows: Respondent was at the nurse's station completing some charting in patient records. At approximately 5:30 to 5:45 p.m., S.S. came out of Room 357 and said her brother needed suctioning. Respondent went to patient J.S.'s room. She did not see him gurgling and no alarms were going on off on his ventilator. Respondent denied that she failed to respond to the nurse call button for 10 minutes.

(B) While Respondent suctioned saliva from patient J.S., S.S. asked Respondent many questions about her brother's condition and care. Respondent denied saying to S.S., "Are you telling me how to do my job?" Respondent answered S.S.'s questions the best she could. Respondent understood that patient J.S.'s other sister, R.M., had the advance care directive, which meant Respondent could only discuss patient J.S.'s case with R.M. S.S. appeared frustrated because Respondent could not answer her questions. Respondent understood S.S.'s frustration, given her brother's medical condition. Respondent offered to call the doctor to answer S.S.'s questions. As Respondent was stepping out of Room 357 to get the doctor, S.S. grabbed her left upper arm, looked into Respondent's eyes and said, "I'm not done talking to you." Respondent responded, "Don't touch me." Respondent was almost outside of Room 357 when S.S. grabbed her a second time by her uniform. Respondent again said, "Don't touch me." Other nurses who heard the verbal exchange intervened, and security was called. S.S. had left the CCU by the time security arrived. Respondent was shaking and fearful for her safety following the incident with S.S. She felt afraid and threatened by S.S.'s conduct. Respondent was following her training when she attempted to leave Room 357 in order to remove herself from a volatile situation with S.S. and to move the situation away from patient J.S.

10. Edna Reyes-Santiago was the charge nurse in the CCU on the day of the March 21, 2002, incident. Ms. Reyes-Santiago was seated at the nurse's station when she heard Respondent say, "I don't want to talk to you right now" and "don't get near me." Ms.

Reyes-Santiago saw Respondent move towards the nurse's station. She got up from the nurse's station and went closer to the scene of the verbal exchange between Respondent and S.S. Ms. Reyes-Santiago attempted to speak with S.S. after the incident, but S.S. declined to speak with her. Ms. Reyes-Santiago checked on the patient J.S. after the incident and saw that he was comfortable and his vital signs were stable.

11. (A) S.S.'s testimony of the March 21, 2002, incident was less convincing than Respondent's testimony. S.S. testified that her brother was having difficulty breathing because of an accumulation of saliva, yet she waited 10 minutes after ringing the nurse call button before going to get a nurse. If her brother was in such distress, one would not expect her to wait 10 minutes before going to look for nurse. There is no indication in the medical records that patient J.S. was suffering from any respiratory distress, or had a physiological response, at or near the time of the incident between Respondent and S.S. S.S.'s testimony that Respondent screamed at her and became angry when she requested suctioning for her brother was not convincing. S.S.'s testimony about Respondent's attitude and state of mind was unconvincing, as one person cannot testify to the state of mind of another person. Respondent's appearance and demeanor throughout the hearing did not reflect a person prone to angry and emotional outbursts. S.S.'s testimony regarding the incident lacked the consistency and sufficiency of detail indicative of credibility. S.S. left the scene of the incident prior to the arrival of the hospital's security staff, which would not be expected if one encountered an angry and combative nurse as S.S. described.

(B) Further, S.S.'s description of Respondent's conduct is indicative her of her overall negative bias against the nursing staff at Good Samaritan Hospital. During her testimony, and in her written correspondence with the Board, S.S. described Respondent and two other nurses involved with her brother's care as angry, aggressive, violent, and having a poor attitude. S.S.'s testimony regarding the details of her touching of Respondent was inconsistent and unpersuasive. On direct examination, S.S. testified that she put her hand on Respondent's shoulder. On cross-examination, S.S. stated that she never touched Respondent's arm and meant to touch her shoulder. In S.S.'s correspondence with the Board, S.S. wrote, "I tried telling her with the tip of my finger on her shoulder to relax," but "right before I even touch [sic] the tip of her blouse . . . [s]he angrily replied 'Don't touch me'." Even Complainant's expert, Peggy Kalowes, R.N., PhD, CNS, acknowledged that the evidence was unclear regarding the extent of S.S.'s touching of Respondent.

12. Respondent's version of events is more logical and convincing. Respondent's demeanor while testifying was honest and sincere. Respondent's contention that S.S. grabbed her arm is corroborated by the testimony of Sussette Narcord. Ms. Narcord is a nurse who was on duty in the CCU on March 21, 2002. She was assigned to care for the patient in the room next door to patient J.S.'s room. Ms. Narcord heard a conversation in the hallway. She saw S.S. grab Respondent on her upper left arm, and heard Respondent say, "Don't touch me." Ms. Narcord testified that another nurse sitting at the nurse station stood up and said, "You heard her, don't touch her." Ms. Narcord heard someone else say, "call security."

13. Based on Findings 8 through 12, Respondent was not aggressive and verbally offensive, angry, or rough, toward S.S. when asked by S.S. to provide suctioning of saliva for patient J.S. on March 21, 2002.

14. At the hearing, both parties presented expert witness testimony. Peggy Kalowes, RN, PhD, testified for Complainant. Rita Serra, BSN, RN, testified for Respondent. Based on their respective backgrounds, education, and experience, Dr. Kalowes and Ms. Serra are qualified to render expert opinions.

15. (A) Complainant's expert, Dr. Kalowes, opined that Respondent was grossly negligent because she knowingly and intentionally committed acts of verbal and physical abuse which adversely affected the physical or psychological welfare of an incapacitated patient and his family. The standard of care requires nurses to respond to patient call buttons immediately and to treat patients and their families courteously and professionally. Dr. Kalowes opined that Respondent violated the standard of care by failing to respond immediately to the nurse call button and then by "overly reacting" when responding to the call button and a family member's request for routine care. Dr. Kalowes opined that Respondent has an inability to control her emotions, based on a 1996 incident documented in Respondent's personnel file. Dr. Kalowes found the 1996 incident was a replica of the incident with S.S. because it involved Respondent having an angry and violent outburst with a charge nurse in front of a patient and family members.

(B) Dr. Kalowes' opinion is unpersuasive, as the evidence does not support the factual basis for her opinion. Dr. Kalowes relied solely on S.S.'s version of the March 21, 2002, incident, which the ALJ has found to be less convincing than Respondent's version. When asked on cross-examination what evidence, other than S.S.'s statement, she relied on to conclude Respondent was verbally abusive and screaming during the incident, Dr. Kalowes stated her clinical experience "implied" it was an explosive situation and that she "was sure" that Respondent's reaction was explosive because security was called. The documentation in Respondent's personnel file regarding the 1996 incident is not clear as to whether the charge nurse or Respondent was the aggressor in the incident. On one document, Respondent commented that she accepted the charge nurse's apology for the incident. The 1996 incident is not probative of the issues regarding the incident between S.S. and Respondent.

16. Respondent's expert, Rita Serra, opined that Respondent acted within the standard of care in responding to S.S.'s request for suctioning for her brother. Ms. Serra noted that the medical records indicated patient J.S. was breathing on his own. There was no indication of respiratory distress or any change in patient J.S.'s vital signs to indicate he had any physiological response to the incident between S.S. and Respondent. In addition, Ms. Serra explained that nurses are trained that they should try to de-escalate a situation when confronted by hostile or assaultive behavior. If de-escalation does not work, the nurse should move away from the hostile or assaultive situation, move away from the patient, and call for help. Ms. Serra opined that Respondent acted within the standard of care because Respondent de-escalated the situation with S.S., who was being confrontational, by moving away from the situation. Ms. Serra's opinion is persuasive.

17. Based on Findings 14 through 16, Respondent's care of patient J.S., and her treatment of S.S., on March 21, 2002, did not constitute gross negligence or unprofessional conduct.

Documentation of Incident

18. Respondent did not document the details of the incident with S.S. in patient J.S.'s medical records, other than to document in the nurse's notes for March 21, 2002 that patient J.S.'s family was at his bedside at 1705 hours (5:05 p.m.).

19. Complainant's expert, Dr. Kalowes, opined that the standard of care is to document in the patient's medical records all aspects of nursing care, including any modifications to the plan of care as well as interventions based on any incidents with the patient's family. Dr. Kalowes opined that Respondent was grossly negligent because she failed to property and legibly document all aspects of patient J.S.'s nursing care, including modifying the plan of care and interventions "based on the critical incident with [S.S.]"

20. Respondent's expert, Ms. Serra, opined that the standard of care does not require a nurse to document an incident in the patient's medical records unless the incident has actual patient involvement, such as, for example, if a patient falls out of his bed. Ms. Serra opined that Respondent acted within the standard of care. Ms. Serra's review of patient J.S.'s medical records indicated he had no physiological response to the incident, and his vital signs showed no physiological effects. Ms. Serra opined that Respondent acted within Good Samaritan Hospital's policy, that "[i]ncident reports (Occurrence reports) are never documented in the medical records." Ms. Serra opined that Respondent properly documented the incident in her letter to the hospital's Human Resources and risk management departments.

21. Ms. Serra's opinion is corroborated by Complainant's own witness, Sonia Ortaliza, R.N., who worked the night shift at Good Samaritan Hospital immediately following the incident. Ms. Ortaliza opined that an incident should be documented in the patient's medical records if the event affects the patient's health and safety. Thus, if a patient in the CCU witnesses an emotional outburst, and the patient's health and safety are affected, then she would expect to see documentation in the patient's medical records.

22. Ms. Serra's opinion was more persuasive than Dr. Kalowes' opinion. The incident at issue in this case did not directly involve patient J.S., but rather was an interaction between Respondent and patient J.S.'s sister. Since there is no evidence that patient J.S. had any adverse response to the incident that required a modification to his plan of care or interventions, it was not established that Respondent had a duty to document the incident in patient J.S.'s medical records.

23. Based on Findings 18 through 22, Respondent's documentation of the incident with S.S. and her care of patient J.S. did not constitute gross negligence or unprofessional conduct.

Allegations of Incompetence

24. On March 26, 2002, Respondent wrote a memo to the Human Resources department of Good Samaritan Hospital detailing her version of the events surrounding the March 21, 2002, incident. Respondent wrote the memo a few days after the incident because she felt threatened and wanted Human Resources to protect her when she was outside of the hospital. She also filed an incident report with the hospital, but did not have a copy of the report.

25. Complainant's expert, Dr. Kalowes, opined that Respondent's memo to Human Resources indicated she was more concerned with advocating for herself rather than being a patient's advocate for patient J.S. Dr. Kalowes discounted Respondent's explanation that she wrote the Human Resources memo because she feared for her safety. Dr. Kalowes felt Respondent had no reason to fear S.S. Dr. Kalowes' opinion is unpersuasive. Based on Findings 18-23, Respondent was not required to document the incident with S.S. in patient J.S.'s medical records. Therefore, Respondent's memo to Human Resources was not an act of advocating for herself over the need to act as a patient advocate for patient J.S. Further, Dr. Kalowes' opinion that Respondent had no reason to fear S.S. was unpersuasive, as Dr. Kalowes was not present or directly involved in the March 21, 2002, incident.

26. The allegation in the Accusation that Respondent failed to accurately and document nursing care, i.e., suctioning, in patient J.S.'s medical records so as to constitute incompetence was not established by clear and convincing evidence. The patient records document that suctioning occurred between 7 and 9 a.m. Dr. Kalowes testified the multidisciplinary/progress record did not document any suctioning between 1400 and 1700 hours, but she acknowledged that suctioning was documented in the patient flowsheet.

27. Based on Findings 24, 25, and 26, Respondent's documentation of the March 21, 2002, incident to Human Resources, her documentation of nursing care she provided to patient J.S., and her interaction with patient J.S. and his sister, did not demonstrate a lack of basic nursing knowledge or skills, and did not constitute acts of incompetence.

Costs

28. Complainant established costs in the amount of $8,238.50, which were reasonably incurred in the investigation and prosecution of this case, as follows:

Expert Witness Fees	$ 525.00
Legal Assistant Fees	$ 955.00
Deputy Attorneys' General Fees	$6,758.50
Total	$8,238.50

LEGAL CONCLUSIONS

1. The standard of proof in an administrative disciplinary action that seeks the suspension or revocation of a registered nurse license is "clear and convincing evidence to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 583.) "Clear and convincing evidence" requires a finding of high probability for the propositions advanced in an Accusation against a licensee. It must be so clear as to leave no substantial doubt and to command the unhesitating assent of every reasonable mind. (*In re Michael G.* (1998) 63 Cal.App.4th 700.)

2. Cause does not exist to discipline Respondent's registered nurse license, pursuant to Business and Professions Code[4] section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16 (CCR), section 1442, for gross negligence, in that was not established by clear and convincing evidence that, on March 21, 2002, while on duty as a registered nurse caring for patient J.S., Respondent was "aggressive and verbally offensive, angry or rough" towards patient J.S.'s sister. (Factual Findings 5-17.)

3. Cause does not exist to discipline Respondent's registered nurse license, pursuant to section 2761, subdivision (a)(1), in conjunction with CCR section 1442, for gross negligence, in that it was not established by clear and convincing evidence that Respondent failed to document the March 21, 2002, incident with patient J.S.'s sister in accordance with the applicable standard of care. (Factual Findings 18-23.)

4. Cause does not exist to discipline Respondent's registered nurse license, pursuant to section 2761, subdivision (a)(1), in conjunction with CCR sections 1443 and 1443.5, for incompetence, in that it was not established by clear and convincing evidence that Respondent committed acts of incompetence while on duty as a registered nurse caring for patient J.S. on March 21, 2002. (Factual Findings 24-27.)

5. Cause does not exist to discipline Respondent's registered nurse license, pursuant to section 2761, subdivision (a), in that it was not established by clear and convincing evidence that Respondent engaged in unprofessional conduct while on duty as a registered nurse caring for patient J.S. on March 21, 2002. (Factual Findings 5-27.)

6. Section 125.3 provides, in pertinent part, that a licentiate found to have committed a violation or violations of the licensing act pertaining to the board or agency in question shall pay a sum not to exceed the reasonable costs of the investigation and prosecution of the matter. In this case, the Board is not entitled to any costs because it was not established that Respondent violated the Nursing Practice Act. (Factual Findings 5-28.)

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[4] All further statutory references are to the Business and Professions Code unless otherwise indicated.

ORDER

The Accusation against Respondent Josefina N. Alincastre Llanos, filed in case number 2008-91, is dismissed.

DATED: March 9, 2009

Erlinda G. Shrenger

ERLINDA G. SHRENGER
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOSEFINA N. ALINCASTRE LLANOS 1206 Norton Ave. Glendale, CA 91202 Registered Nurse License No. 353850 Respondent.	Case No. 2008-91 **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Ruth Ann Terry, M.P.H., R.N. brings this accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about October 31, 1982, the Board issued Registered Nurse License No. 353850 to respondent Josefina N. Alincastre Llanos. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2008, unless renewed.

JURISDICTION

3. This accusation is brought before the Board, under the authority of the

following laws. All Section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . . ."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

10. Section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

11. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

PATIENT J.S.

12. On or about March 20, 2002, patient J.S., a 54 year old male, was transferred from a nursing home and admitted to Good Samaritan Hospital, Los Angeles, California, to be considered for placement of an implantable cardioverter defbrillator (ICD). In the operating room patient J.S. was emergently intubated and placed on a mechanical ventilator. The O.R. doctors determined patient J.S. was in a severely compromised state physiologically, and canceled the ICD procedure. The patient was taken first to the recovery room and then to the coronary care unit (CCU).

13. On or about March 21, 2002, respondent was assigned to care for patient J.S. A sister of patient J.S. became concerned that accumulated saliva was making him uncomfortable. She used the call button to call respondent. When respondent had not appeared after approximately 10 minutes, the sister stepped out of the patient's room to look for her. She saw respondent sitting at the nurses' stating talking to other nurses. Respondent saw the patient's sister and came to the patient's room. When the patient's sister asked respondent if she could clean up the patient's saliva, respondent answered, "Are you telling me how to do my job?" When the patient's sister lightly touched respondent's shoulder and asked her to calm down, respondent began yelling at her in front of the patient. Security responded to patient J.S.'s room. Patient J.S.'s family continued to attend him at his bedside. Respondent failed to document a medical assessment for patient J.S. regarding the either the saliva accumulation or the incident with the patient's sister. Respondent did, however, advocate for herself by documenting the altercation with her human resources department.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent is subject to disciplinary action under Section 2761,

subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, on the grounds of unprofessional conduct, in that on or about March 21, 2002, while on duty as a registered nurse caring for patient J.S., respondent was grossly negligent in her care and treatment of patient J.S.. The circumstances are as follows:

a. The matters alleged in paragraphs 12 through 13 above are realleged and incorporated herein by reference as though fully set forth.

b. The standard of care is to act as the patient's advocate. Respondent was observed being aggressive and verbally offensive, angry or rough towards Patient J.S.'s sister after being asked to provide routine care to the incapacitated patient. Respondent's outburst with the patient's family took time away from performing clinical assessments and nursing interventions to assure the health and well-being of the critically ill patient.

c. Respondent's outburst necessitated intervention by hospital security.

d. Nurses are responsible for establishing and maintaining a therapeutic-nurse client relationship that focuses on the patient's needs. Respondent's outburst with the patient's family was an extreme departure from the standard of care and constituted gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action under Section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, on the grounds of unprofessional conduct, in that on or about March 21, 2002, while on duty as a registered nurse caring for patient J.S., respondent was grossly negligent in her care and treatment of patient J.S.. The circumstances are as follows:

a. The matters alleged in paragraphs 12 through 13 above are realleged and incorporated herein by reference as though fully set forth.

b. The standard of care is to document in the patient's medical records all aspects of nursing care, including any modifications to the plan of care as well as interventions based on any incidents with the patient's family. Respondent failed to document the incident

with the critically ill patient's family as well as any clinical assessments and responses of the patient to the incident.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent is subject to disciplinary action under Section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1443 and 1443.5, on the grounds of unprofessional conduct, in that on or about March 21, 2002, while on duty as a registered nurse caring for patient J.S., respondent committed acts of incompetence. The circumstances are as follows:

a. The matters alleged in paragraphs 12 through 15 above are realleged and incorporated herein by reference as though fully set forth.

b. Respondent's aggressive behavior with the patient's family demonstrates her lack of basic nursing knowledge and skills.

c. Respondent's failure to completely and accurately document nursing care in the patient's medical records demonstrates her lack of basic nursing knowledge and skills.

d. Respondent's documentation of the incident with the patient's family with the hospital's human resources department demonstrates her lack of basic knowledge and skills in a nurse's role as a patient's advocate.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17. Respondent is subject to disciplinary action under Section 2761, subdivision (a), in that on or about March 21, 2002, while on duty as a registered nurse caring for patient J.S., respondent engaged in unprofessional conduct, as set forth in paragraphs 12 through 16 above and incorporated herein by reference as though fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 353850, issued to Josefina N. Alincastre Llanos.

2. Ordering Josefina N. Alincastre Llanos to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/12/07

Ellen Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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